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D&S DIVERSIFIED TECHNOLOGIES (D&SDT)-HEADMASTER

OHIO MEDICATION AIDE EXAMINATION APPLICATION (FORM 1101OM)

A completed Form 1402OM with testing fees must accompany this form.

INSTRUCTIONS:

1. Complete this Medication Aide Examination Application. *Completed paper applications must be received at D&SDT-HEADMASTER 10 business days prior to the testing day excluding Saturdays, Sundays and Holidays or express charges will occur.*
2. Send this completed application along with a completed Scheduling and Payment Form 1402OM and payment to P.O. Box 6609, Helena, MT 59604.

Candidate Information: *Print clearly (use ink) or type*

Are you a veteran, active duty or spouse of a veteran? YES | NO Check which one applies: ____ Veteran ____ Active Duty ____ Spouse
(circle one)

Social Security No.: _____|_____|_____ *(Your social security number will be used to locate your record in our database and provided only to Ohio State Agencies.)*

Applicant's Name: _____ _____ _____ _____
Last First MI Maiden/Former Name

Mailing Address: _____
(P.O. Box # ***-or-*** Street number and name, including Apartment # - if applicable)

City: _____ State: _____ Zip: _____

Cell Phone #: ( ) _____ Home Phone #: ( ) _____

Birth Date (Month/Day/Year): _____|_____|_____ E-Mail Address:_____
(Mandatory) (Providing your email address is your authorization for us to use it for test confirmation and results letters.)

Check off and complete with one of the following choices:

☐ I am an STNA and have successfully completed an Ohio Board of Nursing approved Medication Aide Training Program **within the last sixty days**.

Name of Training Program: _____ Training Code #: _____ Training Completion Date: _____ | _____ | _____

Training Program Address: _____ City: _____ State: _____ ZIP: _____

Attach a copy of your completed MA training certificate.

☐ I am a Residential Care Aide **with one year experience** and have successfully completed an Ohio Board of Nursing approved Medication Aide Training Program **within the last sixty days.**

Name of Training Program: _____ Training Code #: _____ Training Completion Date: _____ | _____ | _____

Training Program Address: _____ City: _____ State: _____ ZIP: _____

Attach a copy of your completed MA training certificate. A letter from the residential care facility on company letterhead must accompany this application documenting that the individual has worked in a residential care facility for a minimum of 1600 hours.

APPLICATIONS WITH INCOMPLETE PROGRAM INFORMATION OR MISSING REQUIRED DOCUMENTATION WILL NOT BE ACCEPTED AND WILL BE RETURNED.

Are you currently employed as a nurse aide? YES | NO Employed since date: _____ | _____ | _____
(circle one) *(month)* *(day)* *(year)*

Facility Name: _____ Facility Address: _____

Facility Phone #: ( ) _____ Facility Email: _____

ADA ACCOMMODATIONS: If you need special accommodations under the Americans with Disabilities Act, please see form 1404OM on the Ohio MA webpage at www.hdmaster.com.

I hereby declare that the above supplied information is true, complete, and accurate to the best of my knowledge. I hereby authorize release of my test results to my training program. I will honor my test appointment and agree to forfeit all test fees as payment for services provided if I do not show up for my test appointment. I will be responsible for any rescheduling, refund fees or dispute fees incurred as described in the Ohio Medication Aide candidate handbook. I understand that I must complete my first test attempt within 60 days of completing the medication aide training program. Please refer to the Ohio MA candidate handbook on the Ohio MA webpage at www.hdmaster.com for testing policies and updates.

Candidate Signature: _____ Date: _____ | _____ | _____
(UNSIGNED AND/OR INCOMPLETE APPLICATIONS WILL BE RETURNED)